Indiana State Department of Health

Indiana Rehabilitation Data Dictionary

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COMMON NULL VALUES

Data Format	[combo] single-choice

Definition

These values are to be used with each of the Indiana Rehabilitation Data Standard Data Elements described in this document which have been defined to accept the Null Values.

Field Values

1 Not Applicable
2 Not Known / Not Recorded

Additional Information

- For any collection of data to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data. When data elements associated with the Indiana Rehabilitation Data Standard are to be electronically stored in a database or moved from one database to another using XML, the indicated null values should be applied

- Not Applicable: This null value code applies if, at the time of patient care documentation, the information requested was "Not Applicable" to the patient, the hospitalization, or the patient care event. For example, variables documenting EMS care would be "Not Applicable" if a patient self-transports to the hospital.

- Not Known / Not Recorded: This null value applies if, at the time of patient care documentation, information was "Not Known" (to the patient, family, or health care provider) or no value for the element recorded for the patient. This documents that there was an attempt to obtain information but it was unknown by all parties or the information was missing at the time of documentation. For example, injury date and time may be documented in the hospital patient care report as "Unknown". Another example, Not Known/Not Recorded should also be coded when documentation was expected, but none was provided (i.e., no EMS run sheet in the hospital record for patient transported by EMS).

Demographic Information

MEDICAL RECORD #

Data Format [text]

Definition

The unique incident number associated with the local rehabilitation registry which can be used for linkage at a later date.

Data Type	*xs: string*		**Element / Domain (Simple Type)**		*MedicalRecordNumber*
Multiple Entry Configuration		No	**Accepts Null Value**	Yes	
Required	Yes		**Min. Constraint:**	**Max. Constraint:**	

Field Values

- Relevant value for data element

REGISTRY #

Data Format [number]

Definition

Trauma registry number

Data Type	*xs: string*	**Element / Domain (Simple Type)**	*IncidentNumber*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

State Element

TR 5.1

INJURY INCIDENT DATE *

Data Format [date]

Definition

The date the injury occurred

XSD Data Type	*xs: date*	**XSD Element / Domain (Simple Type)**	*IncidentDate*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1,990	**Max. Constraint:** 2,030

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Estimates of date of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be used
- If date of injury is "Not recorded / Not known", the null value is unknown

State Element

TR 5.18

INJURY INCIDENT TIME *

Data Format [time]

Definition

The time the injury occurred

XSD Data Type	*xs: time*	**XSD Element / Domain (Simple Type)**	*IncidentTime*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be used
- I2f time of injury is "Not recorded / Not known", the null value is unknown

PATIENT'S LAST NAME

Data Format [text]

Definition

The patient's last name

Data Type	*xs: text*	**Element / Domain (Simple Type)**	*LastName*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

PATIENT'S FIRST NAME

Data Format [text]

Definition

The patient's first name

Data Type	*xs: text*	**Element / Domain (Simple Type)**	*FirstName*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

TR 1.10

PATIENT'S MIDDLE INITIAL

Data Format [text]

Definition

The patient's middle initial

Data Type	*xs: text*	**Element / Domain (Simple Type)**	*MiddleInitial*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

TR 1.11

PATIENT'S SOCIAL SECURITY #

Data Format [number]

Definition

The patient's social security number

Data Type	*xs: number*	**Element / Domain (Simple Type)**	*SSN*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Additional Information

- Collected as ###-##-####

*DATE OF BIRTH**

Data Format [date]

Definition

The patient's date of birth

Data Type	*xs: date*	**Element / Domain (Simple Type)**	*DateOfBirth*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes	**Min. Constraint:** 1,890	**Max. Constraint:** 2,030

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- If age is less than 24 hours, complete variables: Age and Age Units
- If "Not Recorded / Not Known" complete variables: Age and Age Units
- Used to calculate patient age in days, months, or years

*AGE**

Data Format [number]

Definition

The patient's age at the time of injury (best approximation)

Data Type	*xs: integer*		**Element / Domain (Simple Type)**		*Age*
Multiple Entry Configuration		No	**Accepts Null Value**	Yes, common null values	
Required	Yes		**Min. Constraint:** 0	**Max. Constraint:** 120	

Field Values

- Relevant value for data element

Additional Information

- Auto-calculated to patient's age in years when "Date of Birth" is entered
- Used to calculate patient age in hours, days, months, or years
- Only completed when date of birth is "Not Recorded / Not Known" or age is less than 24 hours
- Must also complete variable: Age Units

State Element

TR 1.14

*AGE UNITS**

Data Format [combo] single-choice

Definition

The units used to document the patient's age (Years, Months, Days, Hours)

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*AgeUnits*
		Accepts Null Value	Yes, common null values
Multiple Entry Configuration	No		
Required	Yes		

Field Values

1	Hours	3	Months
2	Days	4	Years

Additional Information

- Used to calculate patient age in hours, days, months, or years
- Only completed when age is less than 24 hours or "Not Recorded/Not Known"
- Must also complete variable: Age

State Element **TR 1.16**

*RACE**

Data Format [combo] multiple-choice

Definition

The patient's race

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*race_element*
Multiple Entry Configuration	Yes, max 2	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 American Indiana or Alaska Native
2 Asian
3 Black or African American
4 Native Hawaiian or Other Pacific Islander
5 Other Race
6 White

Additional Information

- Patient race should be based upon self-report or identified by a family member

OTHER RACE

Data Format [text]

Definition

The patient's secondary race (if the first race field is insufficient)

Data Type	xs: string	**Element/Domain (Simple Type)**	*Race_Other*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Additional Information

- Patient race should be based upon self-report or identified by a family member
- Only completed if Race is "Other Race"

State Element **TR 1.17**

*ETHNICITY**

Data Format [combo] single-choice

Definition

The patient's ethnicity

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Ethnicity*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1	Hispanic or Latino	2	Not Hispanic or Latino

Additional Information

- Patient ethnicity should be based upon self-report or identified by a family member
- The maximum number of ethnicities that may be reported for an individual patient is 1

State Element

TR 1.15

*GENDER (SEX)**

Data Format [combo] single-choice

Definition

The patient's gender (sex)

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Gender*
		Accepts Null	
Multiple Entry Configuration	No	**Value**	Yes, common null values
Required	Yes		

Field Values

1 Female 2 Male

Additional Information

- Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment

EDUCATION LEVEL

Data Format [combo] single-choice

Definition

Level of education successfully completed at the time just prior to the injury

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*LastEducation*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1	College Graduate	6	High School
2	Graduate High School	7	Associate Degree
3	Less than High School	8	Bachelor Degree
4	Postgraduate Education	9	Master's Degree
5	Some College	10	Doctoral Degree
6	Some High School		

Additional Information

- Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment

PRIMARY EMPLOYMENT STATUS

Data Format [combo] single-choice

Definition

Primary employment status

Data Type	*xs: integer*		**Element / Domain (Simple Type)**	*PrimaryEmploymentStatus*
Multiple Entry Configuration		No	**Accepts Null Value**	Yes, common null values
Required	Yes			

Field Values

1	Competitively Employed	11	Special Education/Other Non-Regular Education
2	Full Time Student	12	Special Employed
3	Hospitalized Without Pay During Most of 4 Weeks	13	Taking Care of House or Family
4	On Leave From Work: Not receiving pay	14	Unemployed: Looking
5	Other	15	Unemployed: NOT looking
6	Part Time Student	16	Volunteer Work
7	Refused		
8	Retired: Age-related		
9	Retired: Disability		
10	Retired: Other		

Additional Information

- Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment

PATIENT'S HOME ADDRESS

Data Format [text]

Definition

The home street address of the patient's primary residence

Data Type	xs: string	**Element/Domain (Simple Type)**	*Address*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

State Element

TR 1.19

*PATIENT'S HOME COUNTRY**

Data Format [combo] single-choice

Definition

The country where the patient resides

Data Type	*xs: string*	**Element / Domain (Simple Type)**	*Country*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Additional Information

- When completed with ZIP code, city, county, and state auto-calculate

*PATIENT'S HOME POSTAL CODE (ZIP CODE)**

Data Format [text]

Definition

The patient's ZIP code of primary residence

Data Type	*xs: string*	**Element / Domain (Simple Type)**	*Zip*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Additional Information

- Stored as a 5 digit code
- May require adherence to HIPAA regulations
- When completed with Country the city, county, and state auto-calculate
- If ZIP code is "Not Applicable", complete variable: Alternate Home Residence
- If ZIP code is "Not Recorded / Not Known", complete variables: Patient's Home State ; Patient's Home County; Patient's Home City

State Element **TR 1.21**

*PATIENT'S HOME CITY**

Data Format [combo] single-choice

Definition

The patient's city (or township, or village) of residence

Data Type	*xs: string*	**Element / Domain (Simple Type)**	*City*
		Accepts Null	
Multiple Entry Configuration	No	**Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element (five digit FIPS code)

Additional Information

- Auto-Calculated if ZIP code and Country are completed
- Only complete when ZIP code is "Not Recorded / Not Known"
- Used to calculate FIPS code

State Element **TR 1.22**

*PATIENT'S HOME COUNTY**

Data Format [combo] single-choice

Definition

The patient's county (or parish) of residence

Data Type	*xs: string*	**Element / Domain (Simple Type)**	*County*
		Accepts Null	
Multiple Entry Configuration	No	**Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element (three digit FIPS code)

Additional Information

- Auto-Calculated if ZIP code and Country are completed
- Only complete when ZIP code is "Not Recorded / Not Known"
- Used to calculate FIPS code

State Element **TR 1.23**

*PATIENT'S HOME STATE**

Data Format [combo] single-choice

Definition

The state (territory, province, or District of Columbia) where the patient resides

Data Type	*xs: string*	**Element / Domain (Simple Type)**	*State*
		Accepts Null	
Multiple Entry Configuration	No	**Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element (two digit numeric FIPS code)

Additional Information

- Auto-Calculated if ZIP code and Country are completed
- Only complete when ZIP code is "Not Recorded / Not Known"
- Used to calculate FIPS code

Injury Information

LOCATION SITE

Data Format [combo] single-choice

Definition

E-Code used to describe the place/site/location of the injury event (E 849.X).

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*IncidentLocationType*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Undetermined
2 Home/Residence
3 Farm
4 Mine or Quarry
5 Industrial Place and Premises
6 Place of Recreation or Sport
7 Street or Highway
8 Public Building
9 Residential Institution
10 Other Location

Additional Information

- Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment

*POSTAL CODE (ZIP CODE)**

Data Format [combo] single-choice

Definition

The ZIP code of the incident location.

Data Type	*xs: string*	**Element / Domain (Simple Type)**	*Zip*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Additional Information

- Stored as a 5 digit code
- May require adherence to HIPAA regulations
- When completed with Country the city, county and state auto calculate
- If ZIP code is “Not Applicable”, complete variable: Alternate Home Residence
  If ZIP code is “Not Recorded / Not Known”, complete variables: Patient’s Home
- State; Patient’s Home County; Patient’s Home City

*INCIDENT COUNTRY**

Data Format [combo] single-choice

Definition

The country where the patient was found or to which the unit responded (or best approximation)

Data Type	*xs: string*	**Element / Domain (Simple Type)**	*Country*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Additional Information

- Only complete when Incident Location Zip Code is "Not Applicable" or "Not Recorded / Not Known"
- When completed with Zip Code, the city, county, and state auto-calculate

*INCIDENT CITY**

Data Format [combo] single-choice

Definition

The city or township where the patient was found or to which the unit responded (or best approximation)

Data Type	*xs: string*	**Element / Domain (Simple Type)**	*City*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element (five digit FIPS code)

Additional Information

- Only complete when Incident Location Zip Code is "Not Applicable", or "Not Recorded / Not Known"
- Auto-Calculated if ZIP code and Country are completed
- Used to calculate FIPS code
- If incident location resides outside of formal city boundaries, report nearest city/town

*INCIDENT COUNTY**

Data Format [combo] single-choice

Definition

The county or parish where the patient was found or to which the unit responded (or best approximation)

Data Type	*xs: string*	**Element / Domain (Simple Type)**	*County*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element (three digit FIPS code)

Additional Information

- Only complete when Incident Location Zip Code is "Not Applicable", or "Not Recorded / Not Known"
- Auto-Calculated if ZIP code and Country are completed
- Used to calculate FIPS code

*INCIDENT STATE**

Data Format [combo] single-choice

Definition

The state, territory, or province where the patient was found or to which the unit responded (or best approximation)

Data Type	*xs: string*	**Element / Domain (Simple Type)**	*State*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element (two digit FIPS code)

Additional Information

- Only complete when Incident Location Zip Code is "Not Applicable", or "Not Recorded / Not Known"
- Auto-Calculated if ZIP code and Country are completed
- Used to calculate FIPS code

State Element

TR 200.3

*PRIMARY ICD-10-CM CODE**

Data Format [number]

Definition

External cause code used to describe the mechanism (or external factor) that caused the injury event

Data Type	*xs: string*	**Element / Domain (Simple Type)**	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant ICD-10-CM code value for injury event

Additional Information

- The Primary code should describe the main reason a patient is admitted to the hospital
- Codes are used to auto-generate two calculated fields: Trauma Type: (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix)
- ICD-10-CM Codes will be accepted for this data element. Activity codes should not be reported in this field.

*AIRBAG PRESENT**

Data Format [combo] single-choice

Definition

Airbag in use by the patient at the time of the injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Airbag_Present_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- If airbag is present, complete variables: Airbag not deployed, airbag deployed side, airbag deployed front, airbag deployed other

*AIRBAG NOT DEPLOYED**

Data Format [combo] single-choice

Definition

Indication of no airbag deployment during a motor vehicle crash.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Airbag_Not_Deployed_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

*AIRBAG DEPLOYED SIDE**

Data Format [combo] single-choice

Definition

Indication of airbag deployment on either side of the vehicle during a motor vehicle crash.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Airbag_Deployed_Side_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of airbag deployment may be reported or observed
- Only completed when 'Airbag Present' is marked "Yes"

*AIRBAG DEPLOYED FRONT**

Data Format [combo] single-choice

Definition

Indication of airbag deployment in the front of the vehicle during a motor vehicle crash.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Airbag_Deployed_Front_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- "Airbag Deployed Front" should be used for patients with documented airbag deployments, but are not further specified
- Evidence of the use of airbag deployment may be reported or observed
- Only completed when 'Airbag Present' is marked "Yes"

*AIRBAG DEPLOYED OTHER**

Data Format [combo] single-choice

Definition

Indication of airbag deployment of the knee, airbelt, curtain, etc. during a motor vehicle crash.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Airbag_Deployed_Other_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of airbag deployment may be reported or observed
- Only completed when 'Airbag Present' is marked "Yes"

*CHILD RESTRAINT**

Data Format [combo] single-choice

Definition

Protective child restraint devices used by patient at the time of injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Child_Restraint_id*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- If child restraint is present, complete variables: Infant car seat, child car seat, child booster seat

State Element

TR 29.16

*INFANT CAR SEAT**

Data Format [combo] single-choice

Definition

Infant Car Seat in use by the patient at the time of the injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Infant_Car_Seat_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of child restraint may be reported or observed
- Only completed when 'Child Restraint' is marked "Yes"

State Element **TR 29.15**

*CHILD CAR SEAT**

Data Format [combo] single-choice

Definition

Child Car Seat in use by the patient at the time of injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Child_Car_Seat_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of child restraint may be reported or observed
- Only completed when 'Child Restraint' is marked "Yes"

*CHILD BOOSTER SEAT**

Data Format [combo] single-choice

Definition

Child Booster Seat in use by the patient at the time of injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Child_Booster_Seat_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of child restraint may be reported or observed
- Only completed when 'Child Restraint' is marked "Yes"

*THREE POINT RESTRAINT**

Data Format [combo] single-choice

Definition

Three Point Restraint in use or worn by the patient at the time of the injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Three_Point_Restraint_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- If documentation indicates "Three Point Restraint", "Lap Belt" and "Shoulder Belt" are automatically selected, as well

*LAP BELT**

Data Format [combo] single-choice

Definition

Lap Belt in use or worn by the patient at the time of the injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Lap_Belt_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- Lap Belt should be used to include those patients that are restrained, but not further specified
- If documentation indicates "Three Point Restraint", "Lap Belt" and "Shoulder Belt" are automatically selected, as well

*SHOULDER BELT**

Data Format [combo] single-choice

Definition

Shoulder Belt in use or worn by the patient at the time of the injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Shoulder_Belt_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- If documentation indicates "Three Point Restraint", "Lap Belt" and "Shoulder Belt" are automatically selected, as well

State Element

TR 29.8

*PERSONAL FLOATATION**

Data Format [combo] single-choice

Definition

Personal Floatation Device in use or worn by the patient at the time of the injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Personal_Floatation_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed

State Element **TR 29.6**

*EYE PROTECTION**

Data Format [combo] single-choice

Definition

Eye Protection in use or worn by the patient at the time of the injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Eye_Protection_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed

*HELMET**

Data Format [combo] single-choice

Definition

Helmet (e.g., bicycle, skiing, motorcycle) in use or worn by the patient at the time of the injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Helmet_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed

*PROTECTIVE CLOTHING**

Data Format [combo] single-choice

Definition

Protective clothing (e.g., padded leather pants) in use or worn by the patient at the time of the injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Protective_Clothing_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed

State Element

TR 29.12

*PROTECTIVE NON-CLOTHING GEAR**

Data Format [combo] single-choice

Definition

Protective non-clothing gear (e.g., shin guard) in use or worn by the patient at the time of the injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Protective_Non_Clothing_Gear_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed

State Element **TR 29.9**

*OTHER**

Data Format [combo] single-choice

Definition

Other protective equipment in use or worn by the patient at the time of the injury.

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Other_ID*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes 2 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- If "Yes" is selected, please describe in the box labeled "Safety Description"

SAFETY (Equipment) DESCRIPTION

Data Format [text]

Definition

Other protective equipment in use or worn by the patient at the time of the injury

Data Type	xs string	**Element/Domain (Simple Type)**	*SafetyEquip_Desc*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- Only completed if Other is "Yes"

INJURY DESCRIPTION

Data Format [text]

Definition

The description of injury. This can be any supporting or supplemental data about the injury, other circumstances, etc.

Data Type	xs: string	**Element/Domain (Simple Type)**	*Injury Description*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Additional Information

TR 2.10

*WORK-RELATED**

Data Format [combo] single-choice

Definition

Indication of whether the injury occurred during paid employment

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*WorkRelated*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Yes

2 No

Additional Information

- If work related, two additional data fields must be completed: Patient's Occupational Industry and Patient's Occupation

Rehabilitation Information

REHAB HOSPITAL ADMISSION DATE

Data Format [date]

Definition

Date of admission to the rehabilitation hospital

Data Type	xs: string	**Element/Domain (Simple Type)**	rh_datearrived
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Used to auto-generate an additional calculated field: Total Length of Rehab Hospital Stay (time from rehab hospital admission to rehab hospital discharge)

REHAB HOSPITAL ADMISSION TIME

Data Format [time]

Definition

Time of admission to the rehabilitation hospital

Data Type	xs: string	**Element/Domain (Simple Type)**	RH_timearrived
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Used to auto-generate an additional calculated field: Total Length of Rehab Hospital Stay (time from rehab hospital admission to rehab hospital discharge)

REHAB HOSPITAL DISCHARGE DATE

Data Format [date]

Definition

Date of discharge from the rehabilitation hospital

Data Type	xs: date	**Element/Domain (Simple Type)**	rh_datedischarged
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Used to auto-generate an additional calculated field: Total Length of Rehab Hospital Stay (time from rehab hospital admission to rehab hospital discharge)

REHAB HOSPITAL DISCHARGE TIME

Data Format [time]

Definition

Time of discharge from the rehabilitation hospital

Data Type	xs: string	**Element/Domain (Simple Type)**	rh_timedischarged
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Used to auto-generate an additional calculated field: Total Length of Rehab Hospital Stay (time from rehab hospital admission to rehab hospital discharge)

ASIA IMPAIRMENT SCALE

Data Format [number]

Definition

Describes a person's functional impairment as a result of their spinal cord injury

Data Type	xs: integer	**Element / Domain (Simple Type)**	rh_asia
Multiple Entry Configuration		**Accepts Null Value**	Yes, common null values
Required	Yes	**Min. Constraint:**	**Max. Constraint:**

Field Values

1 A = Complete
2 B = Incomplete
3 C = Incomplete
4 D = Incomplete
5 E = Normal

Additional Information

Clinical Information - Admission

DISABILITY AT ADMISSION - FEEDING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient feeding disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- At the admission evaluation only, if patient does not perform the activity and a helper does not perform the activity for the patient, use code "0: Activity Does Not Occur"
- If the patient is simply not observed performing an activity, do not code "0"

until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - GROOMING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient grooming disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- At the admission evaluation only, if patient does not perform the activity and a helper does not perform the activity for the patient, use code "0: Activity Does Not Occur"
- If the patient is simply not observed performing an activity, do not code "0"

until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - BATHING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bathing disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Bathing*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- At the admission evaluation only, if patient does not perform the activity and a helper does not perform the activity for the patient, use code "0: Activity Does Not Occur"
- If the patient is simply not observed performing an activity, do not code "0"

until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - DRESSING UPPER BODY

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient dressing upper body disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*DressingUpperBody*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- At the admission evaluation only, if patient does not perform the activity and a helper does not perform the activity for the patient, use code "0: Activity Does Not Occur"
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical

record, family members)

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - DRESSING LOWER BODY

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient dressing lower body disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*DressingLowerBody*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- At the admission evaluation only, if patient does not perform the activity and a helper does not perform the activity for the patient, use code "0: Activity Does Not Occur"
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical

record, family members)

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - TOILETING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient toileting disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Toileting*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- At the admission evaluation only, if patient does not perform the activity and a helper does not perform the activity for the patient, use code "0: Activity Does Not Occur"
- If the patient is simply not observed performing an activity, do not code "0"

until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - BLADDER MANAGEMENT

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bladder management disability at admission to the rehabilitation hospital

	xs:			*BladderManagement*
Data Type	*integer*		**Element / Domain (Simple Type)**	
Multiple Entry		N	**Accepts Null**	
Configuration		o	**Value**	Yes, common null values
Required	Yes			

Field Values

0	Activity Does Not Occur	5	Supervision Modified
1	Total Assist	6	Independence Complete
2	Maximal Assist	7	Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date

- If patient does not void (e.g., renal failure and on hemodialysis), assign code "7: Complete Independence"
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - BLADDER LEVEL OF ASSISTANCE

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bladder level of assistance at admission to the rehabilitation hospital

Data Type	*xs: integer*		**Element / Domain (Simple Type)**	*BladderLevelofAssistance*
Multiple Entry		N	**Accepts Null**	
Configuration		o	**Value**	Yes, common null values
Required	Yes			

Field Values

0	Activity Does Not Occur	5	Supervision Modified
1	Total Assist	6	Independence Complete
2	Maximal Assist	7	Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date

If patient does not void (e.g., renal failure and on hemodialysis), assign code "7:

- Complete Independence"
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - BOWEL MANAGEMENT

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bowel management disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*BowelManagement*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - BOWEL LEVEL OF ASSISTANCE

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bowel level of assistance at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Bowellevelofassistance*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - BED TO CHAIR TRANSFERS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bed to chair transfer disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Bedtochair*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- At the admission evaluation only, if patient does not perform the activity and a helper does not perform the activity for the patient, use code "0: Activity Does Not Occur"
- If the patient is simply not observed performing an activity, do not code "0" until

all available sources of information have been consulted (e.g., other clinicians, medical record, family members)

- Not applicable: (e.g., patient less than 7 year's old, patient died, etc.)

DISABILITY AT ADMISSION - TOILET TRANSFERS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient toilet transfer disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*ToiletTransfers*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- At the admission evaluation only, if patient does not perform the activity and a helper does not perform the activity for the patient, use code "0: Activity Does Not Occur"
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians,

medical record, family members)

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - TUB OR SHOWER TRANSFERS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient tub or shower transfer disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Tubortshower*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- At the admission evaluation only, if patient does not perform the activity and a helper does not perform the activity for the patient, use code "0: Activity Does Not Occur"
- If the patient is simply not observed performing an activity, do not code "0" until

all available sources of information have been consulted (e.g., other clinicians, medical record, family members)

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - WALKING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient walking disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Walking*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0 Activity Does Not Occur
1 Total Assist
2 Maximal Assist
3 Moderate Assist
4 Minimal Assist
5 Supervision
6 Modified Independence
7 Complete Independence
9 Unknown: Assessed at > 72 hours

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- The mode of locomotion for FIM item walking or wheelchair must be the same on admission and discharge. If the subject changes the mode of locomotion

from admission to discharge, record the admission mode and score based on the most frequent mode of locomotion at discharge

- Score both modes of locomotion on admission.
- If patient is unable to walk on admission, code Walking On Admission as "1: Total Assist"
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - WHEELCHAIR

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient wheelchair disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Wheelchair*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0 Activity Does Not Occur
1 Total Assist
2 Maximal Assist
3 Moderate Assist
4 Minimal Assist
5 Supervision
6 Modified Independence
7 Complete Independence
9 Unknown: Assessed at > 72 hours

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- The mode of locomotion for FIM item walking or wheelchair must be the same on admission and discharge. If the subject changes the mode of locomotion

from admission to discharge, record the admission mode and score based on the most frequent mode of locomotion at discharge

- Score both modes of locomotion on admission.
- If patient is walking and not using wheelchair, code Wheelchair on Admission as "Not Applicable"
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - STAIRS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient stair disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Stairs*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0 Activity Does Not Occur
1 Total Assist
2 Maximal Assist
3 Moderate Assist
4 Minimal Assist
5 Supervision
6 Modified Independence
7 Complete Independence
9 Unknown: Assessed at > 72 hours

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year's old, patient died, etc.)

DISABILITY AT ADMISSION - COMPREHENSION

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient comprehension disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Comprehension*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Cognitive FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabiltiation is the system discharge date and the FIM scores should correspond to that date
- Wearing of eyeglasses causes Comprehension to be scored "6: Modified Independence" only if the person's primary form of comprehension is visual (rather

than auditory, which is usually primary)

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - EXPRESSION

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient expression disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Expression*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Cognitive FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - SOCIAL INTERACTION

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient social interaction disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*SocialInteraction*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Cognitive FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - PROBLEM SOLVING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient problem solving disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*ProblemSolving*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Cognitive FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - MEMORY

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient memory disability at admission to the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Memory*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Cognitive FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - BLADDER FREQUENCY OF ACCIDENTS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bladder frequency of accidents at admission to the rehabilitation hospital

	xs:			
Data Type	*integer*		**Element / Domain (Simple Type)**	*BladderFrequencyOfAccidents*
Multiple Entry Configuration		No	**Accepts Null Value**	Yes, common null values
Required	Yes			

Field Values

1	5 or more accidents in the past 7 days	5	1 accident in the past 7 days
2	4 accidents in the past 7 days	6	No accidents: uses device
3	3 accidents in the past 7 days	7	No Accidents
4	2 accidents in the past 7 days	9	Unknown: Assessed at > 72 hours

Additional Information

- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered

a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date

- The assessment time period is 7 days - that is, the number of accidents counted across the 7 days prior to the patient's FIM evaluation. Because the admission FIM evaluation must be done at the end of the first 3 days after rehab admission, the assessment time period therefore includes the 4 days prior to rehab admission. If information is not available from this 4-day period, then treat only the 3 days after rehab admission as the assessment time period. No adjustment in scoring is made when the assessment time period is shorter than 7 days.

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - BOWEL FREQUENCY OF ACCIDENTS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bowel frequency of accidents at admission to the rehabilitation hospital

	xs:			
Data Type	*integer*		**Element / Domain (Simple Type)**	*BowelFrequencyofAccidents*
Multiple Entry			**Accepts Null**	
Configuration		No	**Value**	Yes, common null values
Required	Yes			

Field Values

1	5 or more accidents in the past 7 days	5	1 accident in the past 7 days
2	4 accidents in the past 7 days	6	No accidents: uses device
3	3 accidents in the past 7 days	7	No Accidents
4	2 accidents in the past 7 days	9	Unknown: Assessed at > 72 hours

Additional Information

- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then

considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date

- The assessment time period is 7 days - that is, the number of accidents counted across the 7 days prior to the patient's FIM evaluation. Because the admission FIM evaluation must be done at the end of the first 3 days after rehab admission, the assessment time period therefore includes the 4 days prior to rehab admission. If information is not available from this 4-day period, then treat only the 3 days after rehab admission as the assessment time period. No adjustment in scoring is made when the assessment time period is shorter than 7 days.

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - LOCOMOTION MODE

Data Format [combo] single-choice

Definition

Patient's mode of locomotion at admission to rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*LocomotionMode*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Wheelchair
2 Walking

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Admission and Overall FIM Score at Admission
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- The mode of locomotion for FIM item walking or wheelchair must be the same on admission and discharge. If the subject changes the mode of locomotion from admission to discharge, record the admission mode and score based on the most frequent mode of locomotion at discharge
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT ADMISSION - MOTOR FIM SCORE

Data Format [number]

Definition

A score calculated by combining the Feeding, Grooming, Bathing, Upper and Lower Body Dressing, Toileting, Bladder Management, Bowel Management, Bed to Chair Transfer, Toilet Transfer, Tub or Shower Transfer, Stairs, Walking and/or Wheelchair scores, to derive a baseline of patient disability at admission to a rehabilitation hospital

Data Type	xs: string	**Element/Domain (Simple Type)**	MotorFIMScore
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min Constraint:** 13	**Max Constraint:** 91

Field Values

- Relevant value for data element
- Auto-calculated by combining Feeding, Grooming, Bathing, Upper and Lower Body Dressing, Toileting, Bladder Management, Bowel Management, Bed to Chair Transfer, Toilet Transfer, Tub or Shower Transfer, Stairs, Walking and/or Wheelchair scores when entered

DISABILITY AT ADMISSION - COGNITIVE FIM SCORE

Data Format [number]

Definition

A score calculated by combining the Comprehension, Expression, Social Interaction, Problem Solving, and Memory scores, to derive a baseline of patient disability at admission to a rehabilitation hospital

Data Type	xs: string	**Element/Domain (Simple Type)**	CognitiveFIMScore
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes	**Min Constraint:** 5	**Max Constraint:** 35

Field Values

- Relevant value for data element
- Auto-calculated by combining Comprehension, Expression, Social Interaction, Problem Solving, and Memory scores when entered

Additional Information

- If any one of the Cognitive FIM items is unknown, the Cognitive subscore = 999

DISABILITY AT ADMISSION - OVERALL FIM SCORE

Data Format [number]

Definition

A score calculated by combining the Feeding, Grooming, Bathing, Upper and Lower Body Dressing, Toileting, Bladder Management, Bowel Management, Bed to Chair Transfer, Toilet Transfer, Tub or Shower Transfer, Stairs, Walking and/or Wheelchair, Comprehension, Expression, Social Interaction, Problem Solving, and Memory scores, to derive a baseline of patient disability at admission to a rehabilitation hospital

Data Type	xs: string	**Element/Domain (Simple Type)**	OverallFIMScore
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes	**Min Constraint:** 18	**Max Constraint:** 126

Field Values

- Relevant value for data element
- Auto-calculated by combining Feeding, Grooming, Bathing, Upper and Lower Body Dressing, Toileting, Bladder Management, Bowel Management, Bed to Chair Transfer, Toilet Transfer, Tub or Shower Transfer, Stairs, Walking and/or Wheelchair, Comprehension, Expression, Social Interaction, Problem Solving, and Memory scores when entered

Clinical Information – Discharge

DISABILITY AT DISCHARGE - FEEDING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient feeding disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Feeding*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)
- If at discharge evaluation an activity is not performed, assign code "1: Total

Assist". Do not use the code "0: Activity Does Not Occur" at the discharge evaluation.

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - GROOMING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient grooming disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Grooming*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)
- If at discharge evaluation an activity is not performed, assign code "1: Total

Assist". Do not use the code "0: Activity Does Not Occur" at the discharge evaluation.

- Not applicable: (e.g., patient less than 7 year's old, patient died, etc.)

DISABILITY AT DISCHARGE - BATHING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bathing disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Bathing*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)
- If at discharge evaluation an activity is not performed, assign code "1: Total

Assist". Do not use the code "0: Activity Does Not Occur" at the discharge evaluation.

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - DRESSING UPPER BODY

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient dressing upper body disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*DressingUpperBody*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)
- If at discharge evaluation an activity is not performed, assign code "1: Total Assist". Do not use the code "0: Activity Does Not Occur" at the discharge evaluation.

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - DRESSING LOWER BODY

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient dressing lower body disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*DressingLowerBody*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)

- If at discharge evaluation an activity is not performed, assign code "1: Total Assist". Do not use the code "0: Activity Does Not Occur" at the discharge evaluation.

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - TOILETING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient toileting disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Toileting*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)
- If at discharge evaluation an activity is not performed, assign code "1: Total

Assist". Do not use the code "0: Activity Does Not Occur" at the discharge evaluation.

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - BLADDER MANAGEMENT

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bladder management disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*BladderManagement*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- If patient does not void (e.g., renal failure and on hemodialysis), assign code "7: Complete Independence"
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - BLADDER LEVEL OF ASSISTANCE

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bladder level of assistance at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*BladderLevelofAssistance*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- If patient does not void (e.g., renal failure and on hemodialysis), assign code "7: Complete Independence"
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - BOWEL MANAGEMENT

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bowel management disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*BowelManagement*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

DISABILITY AT DISCHARGE - BOWEL LEVEL OF ASSISTANCE

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bowel level of assistance at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*BowelLevelofAssistance*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - BED TO CHAIR TRANSFERS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bed to chair transfer disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*BedtoChair*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)
- If at discharge evaluation an activity is not performed, assign code "1: Total

Assist". Do not use the code "0: Activity Does Not Occur" at the discharge evaluation.

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - TOILET TRANSFERS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient toilet transfer disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*ToiletTransfers*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)
- If at discharge evaluation an activity is not performed, assign code "1: Total Assist". Do not use the code "0: Activity Does Not Occur" at the discharge

evaluation.

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - TUB OR SHOWER TRANSFERS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient tub or shower transfer disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*TubOrShower*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- If the patient is simply not observed performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical record, family members)
- If at discharge evaluation an activity is not performed, assign code "1: Total Assist". Do not use the code "0: Activity Does Not Occur" at the discharge

evaluation.

- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - WALKING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient walking disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Walking*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- The mode of locomotion for FIM item walking or wheelchair must be the same on admission and discharge. If the subject changes the mode of locomotion from admission to discharge, record the admission mode and score based on

the most frequent mode of locomotion at discharge

- Score both modes of locomotion on discharge
- If at discharge, patient is walking AND using a wheelchair, code the more frequently used mode of locomotion. If the more frequent mode of locomotion cannot be determined, code as "9: Unknown"
- Not applicable: (e.g., patient less than 7 year's old, patient died, etc.)

DISABILITY AT DISCHARGE - WHEELCHAIR

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient wheelchair disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Wheelchair*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- The mode of locomotion for FIM item walking or wheelchair must be the same on admission and discharge. If the subject changes the mode of locomotion from admission to discharge, record the admission mode and score based on

the most frequent mode of locomotion at discharge

- Score both modes of locomotion on discharge
- If at discharge, patient is walking AND using a wheelchair, code the more frequently used mode of locomotion. If the more frequent mode of locomotion cannot be determined, code as "9: Unknown"
- Not applicable: (e.g., patient less than 7 year's old, patient died, etc.)

DISABILITY AT DISCHARGE - STAIRS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient stair disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Stairs*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - COMPREHENSION

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient comprehension disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Comprehension*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate an additional calculated field: Cognitive FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Wearing of eyeglasses causes Comprehension to be scored "6: Modified Independence" only if the person's primary form of comprehension is visual (rather than auditory, which is usually primary)
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - EXPRESSION

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient expression disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Expression*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate an additional calculated field: Cognitive FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - SOCIAL INTERACTION

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient social interaction disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*SocialInteraction*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate an additional calculated field: Cognitive FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - PROBLEM SOLVING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient problem solving disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*ProblemSolving*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate an additional calculated field: Cognitive FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - MEMORY

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient memory disability at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*Memory*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

0	Activity Does Not Occur	5	Supervision
1	Total Assist	6	Modified Independence
2	Maximal Assist	7	Complete Independence
3	Moderate Assist	9	Unknown: Assessed at > 72 hours
4	Minimal Assist		

Additional Information

- Used to auto-generate an additional calculated field: Cognitive FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - BLADDER FREQUENCY OF ACCIDENTS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bladder frequency of accidents at discharge from the rehabilitation hospital

		Element / Domain (Simple Type)	
Data Type	*xs: integer*	BladderFrequencyOfAccidents	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 5 or more accidents in the past 7 days
2 4 accidents in the past 7 days
3 3 accidents in the past 7 days
4 2 accidents in the past 7 days
5 1 accident in the past 7 days
6 No accidents: uses device
7 No Accidents
9 Unknown: Assessed at > 72 hours

Additional Information

- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- The assessment time period is 7 days - that is, the number of accidents

counted across the 7 days prior to the patient's FIM evaluation. Because the admission FIM evaluation must be done at the end of the first 3 days after rehab admission, the assessment time period therefore includes the 4 days prior to rehab admission. If information is not available from this 4-day period, then treat only the 3 days after rehab admission as the assessment time period. No adjustment in scoring is made when the assessment time period is shorter than 7 days.

- Not applicable: (e.g., patient less than 7 year's old, patient died, etc.)

DISABILITY AT DISCHARGE - BOWEL FREQUENCY OF ACCIDENTS

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of patient bowel frequency of accidents at discharge from the rehabilitation hospital

		Element / Domain (Simple Type)	
Data Type	*xs: integer*	BowelFrequencyOfAccidents	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1	5 or more accidents in the past 7 days	5	1 accident in the past 7 days
2	4 accidents in the past 7 days	6	No accidents: uses device
3	3 accidents in the past 7 days	7	No Accidents
4	2 accidents in the past 7 days	9	Unknown: Assessed at > 72 hours

Additional Information

- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- The assessment time period is 7 days - that is, the number of accidents

counted across the 7 days prior to the patient's FIM evaluation. Because the admission FIM evaluation must be done at the end of the first 3 days after rehab admission, the assessment time period therefore includes the 4 days prior to rehab admission. If information is not available from this 4-day period, then treat only the 3 days after rehab admission as the assessment time period. No adjustment in scoring is made when the assessment time period is shorter than 7 days.

- Not applicable: (e.g., patient less than 7 year's old, patient died, etc.)

DISABILITY AT DISCHARGE - LOCOMOTION MODE

Data Format [combo] single-choice

Definition

Patient's mode of locomotion at discharge from the rehabilitation hospital

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*LocomotionMode*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Wheelchair
2 Walking

Additional Information

- Used to auto-generate additional calculated fields: Motor FIM Score at Discharge and Overall FIM Score at Discharge
- All FIM items must be scored
- Record what patient actually does
- If FIM assessment cannot be completed within the window of 3 calendar days, use code "9: Unknown"
- If the patient would be put at risk for injury if tested or does not perform the activity, use code "1: Total Assist"
- If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge
- If a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date
- The mode of locomotion for FIM item walking or wheelchair must be the same on admission and discharge. If the subject changes the mode of locomotion from admission to discharge, record the admission mode and score based on the most frequent mode of locomotion at discharge
- If at discharge, patient is walking AND using a wheelchair, code the more frequently used mode of locomotion. If the more frequent mode of locomotion cannot be determined, code as "9: Unknown"
- Not applicable: (e.g., patient less than 7 year’s old, patient died, etc.)

DISABILITY AT DISCHARGE - MOTOR FIM SCORE

Data Format [number]

Definition

A score calculated by combining the Feeding, Grooming, Bathing, Upper and Lower Body Dressing, Toileting, Bladder Management, Bowel Management, Bed to Chair Transfer, Toilet Transfer, Tub or Shower Transfer, Stairs, Walking and/or Wheelchair scores, to derive a baseline of patient disability at discharge from a rehabilitation hospital

Data Type	xs: string	**Element / Domain (Simple Type)**	MotorFIMScore
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes	**Min Constraint:** 13	**Max Constraint:** 91

Field Values

- Relevant value for data element
- Auto-calculated by combining Feeding, Grooming, Bathing, Upper and Lower Body Dressing, Toileting, Bladder Management, Bowel Management, Bed to Chair Transfer, Toilet Transfer, Tub or Shower Transfer, Stairs, Walking and/or Wheelchair scores when entered

DISABILITY AT DISCHARGE - COGNITIVE FIM SCORE

Data Format [number]

Definition

A score calculated by combining the Comprehension, Expression, Social Interaction, Problem Solving, and Memory scores, to derive a baseline of patient disability at discharge from a rehabilitation hospital

Data Type	xs: string	**Element/Domain (Simple Type)**	CognitiveFIMScore
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes	**Min Constraint:** 5	**Max Constraint:** 35

Field Values

- Relevant value for data element
- Auto-calculated by combining Comprehension, Expression, Social Interaction, Problem Solving, and Memory scores when entered

Additional Information

- If any one of the Cognitive FIM items is unknown, the Cognitive subscore = 999

DISABILITY AT DISCHARGE - OVERALL FIM SCORE

Data Format [number]

Definition

A score calculated by combining the Feeding, Grooming, Bathing, Upper and Lower Body Dressing, Toileting, Bladder Management, Bowel Management, Bed to Chair Transfer, Toilet Transfer, Tub or Shower Transfer, Stairs, Walking and/or Wheelchair, Comprehension, Expression, Social Interaction, Problem Solving, and Memory scores, to derive a baseline of patient disability at discharge from a rehabilitation hospital

Data Type	xs: string	**Element/Domain (Simple Type)**	OverallFIMScore
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes	**Min Constraint:** 18	**Max Constraint:** 126

Field Values

- Relevant value for data element
- Auto-calculated by combining Feeding, Grooming, Bathing, Upper and Lower Body Dressing, Toileting, Bladder Management, Bowel Management, Bed to Chair Transfer, Toilet Transfer, Tub or Shower Transfer, Stairs, Walking and/or Wheelchair, Comprehension, Expression, Social Interaction, Problem Solving, and Memory scores when entered

Outcome Information

State Element **TR 2.5**

*PRIMARY METHOD OF PAYMENT**

Data Format [combo] single-choice

Definition

Primary source of payment for hospital care

Data Type	*xs: integer*	**Element / Domain (Simple Type)**	*billinginfo*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Medicaid
2 Not Billed (for any reason)
3 Self Pay
4 Private / Commercial Insurance
5 Medicare
6 Other Government
7 Workers Compensation
8 Managed Care
9 Other

OTHER BILLING SOURCE

Data Format [text]

Definition

Other billing source that is not specific in the Primary Method of Payment drop-down menu

Data Type	xs: string	**Element/Domain (Simple Type)**	otherBillingInfo
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Additional Information

- Only completed if Primary Method of Payment is "Other"

SECONDARY METHOD OF PAYMENT

Data Format [combo] single-choice

Definition

Any known secondary source of finance expected to assist in payment of medical bills

Data Type	xs: integer	**Element/Domain (Simple Type)**	SecondaryBillingInfo
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

1 Medicare Supp
2 Managed Care
3 No Fault Automobile
4 Not Billed (for any reason)
5 Medicare
6 Medicaid
7 Private / Commercial Insurance
8 Workers Compensation
9 Other
10 Self Pay
11 Other Government

SECONDARY OTHER BILLING SOURCE

Data Format [text]

Definition

Secondary other billing source that is not specific in the Secondary Method of Payment drop-down menu

Data Type	xs: string	**Element/Domain (Simple Type)**	secondaryotherbillinginfo
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Additional Information

- Only completed if Secondary Method of Payment is "Other"

BILLED HOSPITAL CHARGES

Data Format [number]

Definition

The total amount the hospital charged for the patient's care

Data Type	xs: string	**Element/Domain (Simple Type)**	BillingCharges
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

REIMBURSED CHARGES

Data Format [number]

Definition

The amount the hospital was reimbursed for services

Data Type	xs: string	**Element/Domain (Simple Type)**	reimbursedcharges
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Disposition from Rehab

Data Format [number]

Definition

Disposition from Rehab

Data Type	xs: string	**Element/Domain (Simple Type)**	rh_datedischarged
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required	Yes		

Field Values

- Relevant value for data element

Appendix 1: Auto Calculated Variables Based Upon Existing Data Elements

Variables Auto-Calculated Based on Existing Data Elements

1. *Computed Motor FIM at Admission (Data Element:)*

   Definition: Sum of all parts that make up Motor FIM score at patient's admission to rehabilitation hospital

   Calculation: Disability at Admission-Feeding + Disability at Admission-Grooming + Disability at Admission-Bathing + Disability at Admission-Dressing Upper Body + Disability at Admission-Dressing Lower Body + Disability at Admission-Toileting + Disability at Admission-Bladder Management + Disability at Admission-Bowel Management + Disability at Admission-Bed to Chair Transfers + Disability at Admission-Toilet Transfers + Disability at Admission-Tub or Shower Transfers + Disability at Admission-Walking + Disability at Admission-Wheelchair + Disability at Admission-Stairs

2. *Total Cognitive FIM at Admission (Data Element:)*

   Definition: Sum of all parts that make up Cognitive FIM score at patient's admission to rehabilitation hospital

   Calculation: Disability at Admission-Comprehension + Disability at Admission-Expression + Disability at Admission-Social Interaction + Disability at Admission-Problem Solving + Disability at Admission-Memory

3. *Total Overall FIM at Admission (Data Element:)*

   Definition: Sum of all parts that make up overall FIM score at patient's admission to rehabilitation hospital

   Calculation: Disability at Admission-Feeding + Disability at Admission-Grooming + Disability at Admission-Bathing + Disability at Admission-Dressing Upper Body + Disability at Admission-Dressing Lower Body + Disability at Admission-Toileting + Disability at Admission-Bladder Management + Disability at Admission-Bowel Management + Disability at Admission-Bed to Chair Transfers + Disability at Admission-Toilet Transfers + Disability at Admission-Tub or Shower Transfers + Disability at Admission-Walking + Disability at Admission-Wheelchair + Disability at Admission-Stairs + Disability at Admission-Comprehension + Disability at Admission-Expression + Disability at Admission-Social Interaction + Disability at Admission-Problem Solving + Disability at Admission-Memory

4. *Total Length of Rehabilitation Hospital Stay (Data Element:)*

   Definition: The total elapsed time the patient was in the hospital.

Calculation: Rehab Hospital Discharge DateTime – Rehab Hospital Arrival DateTime

5. *Total Motor FIM at Discharge (Data Element:)*

   Definition: Sum of all parts that make up Motor FIM score at patient's discharge from rehabilitation hospital

   Calculation: Disability at Discharge-Feeding + Disability at Discharge-Grooming + Disability at Discharge -Bathing + Disability at Discharge -Dressing Upper Body + Disability at Discharge -Dressing Lower Body + Disability at Discharge -Toileting + Disability at Discharge -Bladder Management + Disability at Discharge -Bowel Management + Disability at Discharge -Bed to Chair Transfers + Disability at Discharge -Toilet Transfers + Disability at Discharge -Tub or Shower Transfers + Disability at Discharge -Walking + Disability at Discharge -Wheelchair + Disability at Discharge -Stairs

6. *Total Cognitive FIM at Discharge (Data Element:)*

   Definition: Sum of all parts that make up Cognitive FIM score at patient's discharge from rehabilitation hospital

   Calculation: Disability at Discharge-Comprehension + Disability at Discharge -Expression + Disability at Discharge -Social Interaction + Disability at Discharge -Problem Solving + Disability at Discharge -Memory

7. *Total Overall FIM at Discharge (Data Element:)*

   Definition: Sum of all parts that make up overall FIM score at patient's discharge from rehabilitation hospital

   Calculation: Disability at Discharge-Feeding + Disability at Discharge-Grooming + Disability at Discharge -Bathing + Disability at Discharge -Dressing Upper Body + Disability at Discharge -Dressing Lower Body + Disability at Discharge -Toileting + Disability at Discharge -Bladder Management + Disability at Discharge -Bowel Management + Disability at Discharge -Bed to Chair Transfers + Disability at Discharge -Toilet Transfers + Disability at Discharge -Tub or Shower Transfers + Disability at Discharge -Walking + Disability at Discharge -Wheelchair + Disability at Discharge –Stairs + Disability at Discharge-Comprehension + Disability at Discharge -Expression + Disability at Discharge -Social Interaction + Disability at Discharge -Problem Solving + Disability at Discharge -Memory

8. *Change in FIM – Eating (Data Element:)*

   Definition: Change in patient's disability when eating from admission to discharge at the rehabilitation hospital

Calculation: Disability at Discharge-Eating – Disability at Admission-Eating

9. *Change in FIM – Grooming (Data Element:)*

   Definition: Change in patient's disability when grooming from admission to discharge at the rehabilitation hospital

   Calculation: Disability at Discharge-Grooming – Disability at Admission-Grooming

10. *Change in FIM – Bathing (Data Element:)*

    Definition: Change in patient's disability when bathing from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Bathing – Disability at Admission-Bathing

11. *Change in FIM – Upper Body Dressing (Data Element:)*

    Definition: Change in patient's disability when dressing their upper body from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Upper Body Dressing – Disability at Admission-Upper Body Dressing

12. *Change in FIM – Lower Body Dressing (Data Element:)*

    Definition: Change in patient's disability when dressing their lower body from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Lower Body Dressing – Disability at Admission-Lower Body Dressing

13. *Change in FIM – Toileting (Data Element:)*

    Definition: Change in patient's disability when toileting from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Toileting – Disability at Admission-Toileting

14. *Change in FIM – Bladder Management (Data Element:)*

    Definition: Change in patient's disability when managing their bladder from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Bladder Management – Disability at Admission-Bladder Management

15. *Change in FIM – Bowel Management (Data Element:)*

    Definition: Change in patient's disability when managing their bowels from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Bowel Management – Disability at Admission-Bowel Management

16. *Change in FIM – Bed to Chair Transfer (Data Element:)*

    Definition: Change in patient's disability when transferring from a bed to a chair from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Bed to Chair Transfer – Disability at Admission-Bed to Chair Transfer

17. *Change in FIM – Toilet Transfer (Data Element:)*

    Definition: Change in patient's disability when transferring to and from the toilet from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Toilet Transfer – Disability at Admission-Toilet Transfer

18. *Change in FIM – Tub or Shower Transfer (Data Element:)*

    Definition: Change in patient's disability when transferring to and from the shower or tub from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Tub or Shower Transfer – Disability at Admission-Tub or Shower Transfer

19. *Change in FIM – Walking (Data Element:)*

    Definition: Change in patient's disability when walking from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Walking – Disability at Admission-Walking

20. *Change in FIM – Wheelchair (Data Element:)*

    Definition: Change in patient's disability when using a wheelchair from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Wheelchair – Disability at Admission-Wheelchair

21. *Change in FIM – Stairs (Data Element:)*

Definition: Change in patient's disability when using the stairs from admission to discharge at the rehabilitation hospital

Calculation: Disability at Discharge-Stairs – Disability at Admission-Stairs

22. *Change in FIM – Cognitive Comprehension (Data Element:)*

    Definition: Change in patient's comprehension disability from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Comprehension – Disability at Admission-Comprehension

23. *Change in FIM – Expression (Data Element:)*

    Definition: Change in patient's expression disability from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Expression – Disability at Admission-Expression

24. *Change in FIM – Social Interaction (Data Element:)*

    Definition: Change in patient's social interaction disability from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Social Interaction – Disability at Admission-Social Interaction

25. *Change in FIM – Problem Solving (Data Element:)*

    Definition: Change in patient's problem solving disability from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Problem Solving – Disability at Admission-Problem Solving

26. *Change in FIM – Memory (Data Element:)*

    Definition: Change in patient's memory disability from admission to discharge at the rehabilitation hospital

    Calculation: Disability at Discharge-Memory – Disability at Admission-Memory

27. *Change in FIM – Overall Motor (Data Element:)*

    Definition: Change in patient's overall motor disability from admission to discharge at the rehabilitation hospital

Calculation: (Disability at Discharge-Feeding + Disability at Discharge-Grooming + Disability at Discharge -Bathing + Disability at Discharge -Dressing Upper Body + Disability at Discharge -Dressing Lower Body + Disability at Discharge -Toileting + Disability at Discharge -Bladder Management + Disability at Discharge -Bowel Management + Disability at Discharge -Bed to Chair Transfers + Disability at Discharge -Toilet Transfers + Disability at Discharge -Tub or Shower Transfers + Disability at Discharge -Walking + Disability at Discharge -Wheelchair + Disability at Discharge –Stairs) – (Disability at Admission-Feeding + Disability at Admission-Grooming + Disability at Admission-Bathing + Disability at Admission-Dressing Upper Body + Disability at Admission-Dressing Lower Body + Disability at Admission-Toileting + Disability at Admission-Bladder Management + Disability at Admission-Bowel Management + Disability at Admission-Bed to Chair Transfers + Disability at Admission-Toilet Transfers + Disability at Admission-Tub or Shower Transfers + Disability at Admission-Walking + Disability at Admission-Wheelchair + Disability at Admission-Stairs)

28. *Change in FIM – Overall Cognitive (Data Element:)*

    Definition: Change in patient's overall cognitive disability from admission to discharge at the rehabilitation hospital

    Calculation: (Disability at Discharge-Comprehension + Disability at Discharge -Expression + Disability at Discharge -Social Interaction + Disability at Discharge -Problem Solving + Disability at Discharge –Memory) – (Disability at Admission-Comprehension + Disability at Admission-Expression + Disability at Admission-Social Interaction + Disability at Admission-Problem Solving + Disability at Admission-Memory)

29. *Change in FIM – Overall (Data Element:)*

    Definition: Change in patient's overall FIM from admission to discharge at the rehabilitation hospital

    Calculation: (Disability at Discharge-Feeding + Disability at Discharge-Grooming + Disability at Discharge -Bathing + Disability at Discharge -Dressing Upper Body + Disability at Discharge -Dressing Lower Body + Disability at Discharge -Toileting + Disability at Discharge -Bladder Management + Disability at Discharge -Bowel Management + Disability at Discharge -Bed to Chair Transfers + Disability at Discharge -Toilet Transfers + Disability at Discharge -Tub or Shower Transfers + Disability at Discharge -Walking + Disability at Discharge -Wheelchair + Disability at Discharge –Stairs + Disability at Discharge-Comprehension + Disability at Discharge -Expression + Disability at Discharge -Social Interaction + Disability at Discharge -Problem Solving + Disability at Discharge –Memory) – (Disability at Admission-

Feeding + Disability at Admission-Grooming + Disability at Admission-Bathing + Disability at Admission-Dressing Upper Body + Disability at Admission-Dressing Lower Body + Disability at Admission-Toileting + Disability at Admission-Bladder Management + Disability at Admission-Bowel Management + Disability at Admission-Bed to Chair Transfers + Disability at Admission-Toilet Transfers + Disability at Admission-Tub or Shower Transfers + Disability at Admission-Walking + Disability at Admission-Wheelchair + Disability at Admission-Stairs + Disability at Admission-Comprehension + Disability at Admission-Expression + Disability at Admission-Social Interaction + Disability at Admission-Problem Solving + Disability at Admission-Memory)

30. *FIM Efficiency (Data Element:)*

    Definition: The rate of FIM change with time

    Calculation: Change in FIM-Overall / Total Length of Rehabilitation Hospital Stay

31. *Overall M2PI Score (Data Element:)*

    Definition: Sum of all parts that make up M2PI score

    Calculation: M2PI Score-Initiation + M2PI Score-Social Contact + M2PI Score-Leisure Activities + M2PI Score-Self-Care + M2PI Score-Residence + M2PI Score-Transportation + (M2PI Score-Paid Employment OR M2PI Score-Other Employment) + M2PI Score-Money and Finances

32. *Disability Rating Scale – Postacute Interview (DRS-PI) Score (Data Element:)*

    Definition:

    Calculation:

DRS-PI and Expanded DRS-PI Scoring Algorithms: Research Questionnaire → DRS		
DRS Item	Research Questionnaire	DRS Item Score
1	N/A	Score = 0
2	If 2.3 = 0	0
	If 2.3 = 1 or 2 or 3	1
	N/A for Survivor Version If 2.4 = 1	2
	N/A for Survivor Version If 2.5 =1	2

	N/A for Survivor Version If 2.4 = 0 and 2.5 = 0	2
4	If 4.1 = YES (0)	0
	If 4.2 + 4.3 = 0	0
	If 4.2 + 4.3 = 1-3	1
	If 4.2 + 4.3 = 4-5	2
	If 4.2 + 4.3 = 6	3
5	If 5.1 = YES (0)	0
	If 5.2 + 5.3 = 0	0
	If 5.2 + 5.3 = 1-3	1
	If 5.2 + 5.3 = 4-5	2
	If 5.2 + 5.3 = 6	3
6	If 6.1 = YES (0)	0
	If sum of scores 6.3 to 6.5 = 0	0
	If sum of scores 6.3 to 6.5 = 1-4	1
	If sum of scores 6.3 to 6.5 = 5-8	2
	If sum of scores 6.3 to 6.5 = 9	3
7	If 7.1 = 0	0 Completely Independent
	If 7.1 =1 but 7.2 through 7.7c = 0	0 Completely Independent
	If 7.2 =1 and 7.3 through 7.5 = 0	1 Independent in Special Environment
	If any of 7.3 through 7.5 = 1 and none = 2 or 3	2 Mildly Dependent-limited assistance
	If any of 7.3 through 7.5 = 2 or 3 AND/OR 7.7a = 1	3 Moderately Dependent-moderate assist

	If 7.7b = 1 and 7.7c = 0 (regardless of responses to 7.2-7.7a)	4 Markedly Dependent-assist all major activities, all times
	If 7.7c = 1 (regardless of responses to 7.2-7.7b)	5 Totally Dependent - 24 hour nursing care
8	If all of 8.1, 8.3, 8.4, and 8.12 = 0 or 1	0
	If any of 8.1, 8.3, or 8.4 = 2 or 3	1
	8.12 = 2-4; and 8.13 and 8.14 = 0 or 1	1
	If 8.13 or 8.14 = 2, 3, or 4 and 8.15 = 0 or 1	2
	If 8.15 = 2, 3, or 4	3

Sum scores based on algorithm for items: 2 _____

4 _____

5 _____

6 _____

7 _____

8 _____

Sum yields DRS-PI score

(equivalent to Original DRS score) _____*

33. Expanded DRS-PI Score (Data Element:)

Definition:

Calculation:

DRS-PI and Expanded DRS-PI Scoring Algorithms: Research Questionnaire → DRS		
DRS Item	Research Questionnaire	DRS Item Score
1	N/A	Score = 0

2	If 2.3 = 0	0
	If 2.3 = 1 or 2 or 3	1
	N/A for Survivor Version If 2.4 = 1	2
	N/A for Survivor Version If 2.5 =1	2
	N/A for Survivor Version If 2.4 = 0 and 2.5 = 0	2
4	If 4.1 = YES (0)	0
	If 4.2 + 4.3 = 0	0
	If 4.2 + 4.3 = 1-3	1
	If 4.2 + 4.3 = 4-5	2
	If 4.2 + 4.3 = 6	3
5	If 5.1 = YES (0)	0
	If 5.2 + 5.3 = 0	0
	If 5.2 + 5.3 = 1-3	1
	If 5.2 + 5.3 = 4-5	2
	If 5.2 + 5.3 = 6	3
6	If 6.1 = YES (0)	0
	If sum of scores 6.3 to 6.5 = 0	0
	If sum of scores 6.3 to 6.5 = 1-4	1
	If sum of scores 6.3 to 6.5 = 5-8	2
	If sum of scores 6.3 to 6.5 = 9	3
7	If 7.1 = 0	0 Completely Independent
	If 7.1 =1 but 7.2 through 7.7c = 0	0 Completely Independent
	If 7.2 =1 and 7.3 through 7.5 = 0	1 Independent in Special Environment

	If any of 7.3 through 7.5 = 1 and none = 2 or 3	2 Mildly Dependent-limited assistance
	If any of 7.3 through 7.5 = 2 or 3 AND/OR 7.7a = 1	3 Moderately Dependent-moderate assist
	If 7.7b = 1 and 7.7c = 0 (regardless of responses to 7.2-7.7a)	4 Markedly Dependent-assist all major activities, all times
	If 7.7c = 1 (regardless of responses to 7.2-7.7b)	5 Totally Dependent - 24 hour nursing care
8	If all of 8.1, 8.3, 8.4, and 8.12 = 0 or 1	0
	If any of 8.1, 8.3, or 8.4 = 2 or 3	1
	8.12 = 2-4; and 8.13 and 8.14 = 0 or 1	1
	If 8.13 or 8.14 = 2, 3, or 4 and 8.15 = 0 or 1	2
	If 8.15 = 2, 3, or 4	3

Sum scores based on algorithm for items: 2 _____

4 _____

5 _____

6 _____

7 _____

8 _____

Sum yields DRS-PI score

(equivalent to Original DRS score) _____*

To obtain Expanded DRS-PI score,

add in scores for items: 7.1 _____

8.1 _____

8.3 _____

8.4 _____

Subtotal =DRS-PI Sum* + 7.1 thru 8.4: _____**

Add score for Employment Category (below) _____

If no score (missing),

Add 1 if Subtotal = 0 or 1

Add 2 if Subtotal = 2

Add 3 if Subtotal = 3-7

Add 4 if Subtotal = 8 or greater

Expanded DRS-PI Score _____

(Add employment score and

Subtotal score**)

02 Full-time student	= 0
03 Part-time student	= 2
04Spec education	= 2
05 Competitively employed	= 0
07 Taking care of house	= 2
08 Spec employed	= 2
09 Retired (age)	= no score (missing)
10 Unemployed (looking)	= 2
11 Volunteer work	= 2
12 Retired (disability)	= 4
13 Unemployed (not looking)	= 4
14 Hospitalized	= no score (missing)
15 Retired (other)	= no score (missing)
16 On leave	= no score (missing)
55 Other	= no score (missing)